HNP and the Poor: The Health System and the Poor

Session 4

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Session Objectives

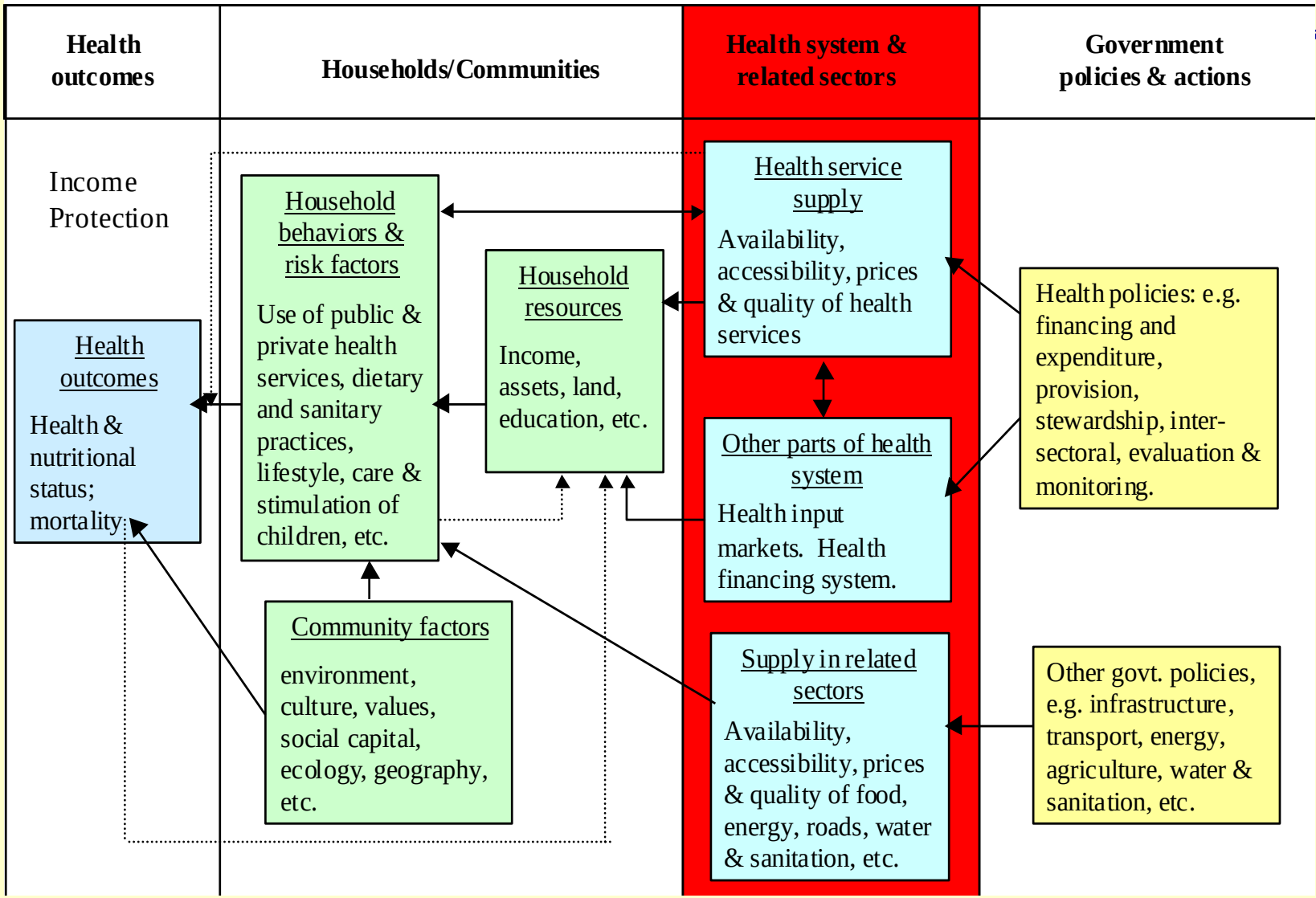
To answer the following questions:

- **How to assess the performance of the health sector in serving the poor?**
- **How health financing functions are related to assuring that an adequate volume and quality of services are accessible to the poor?**
- **What have we learned from HIPC countries preparing PRSPs?**

Session Outline

- **Fit with the PRSP framework**
- **Eight dimensions of performance, and for each:**
  - **diagnostics**
  - **pro-poor actions**
  - **country examples**
- **Health financing and the poor**
  - **patterns of government spending**
  - **strategies for mobilizing resources**

Determinants of Health Outcomes



Are Health Systems Important ?

- **Typically, most improvements in health outcomes in Europe over the 19th and early 20th century are attributable to increase in income**

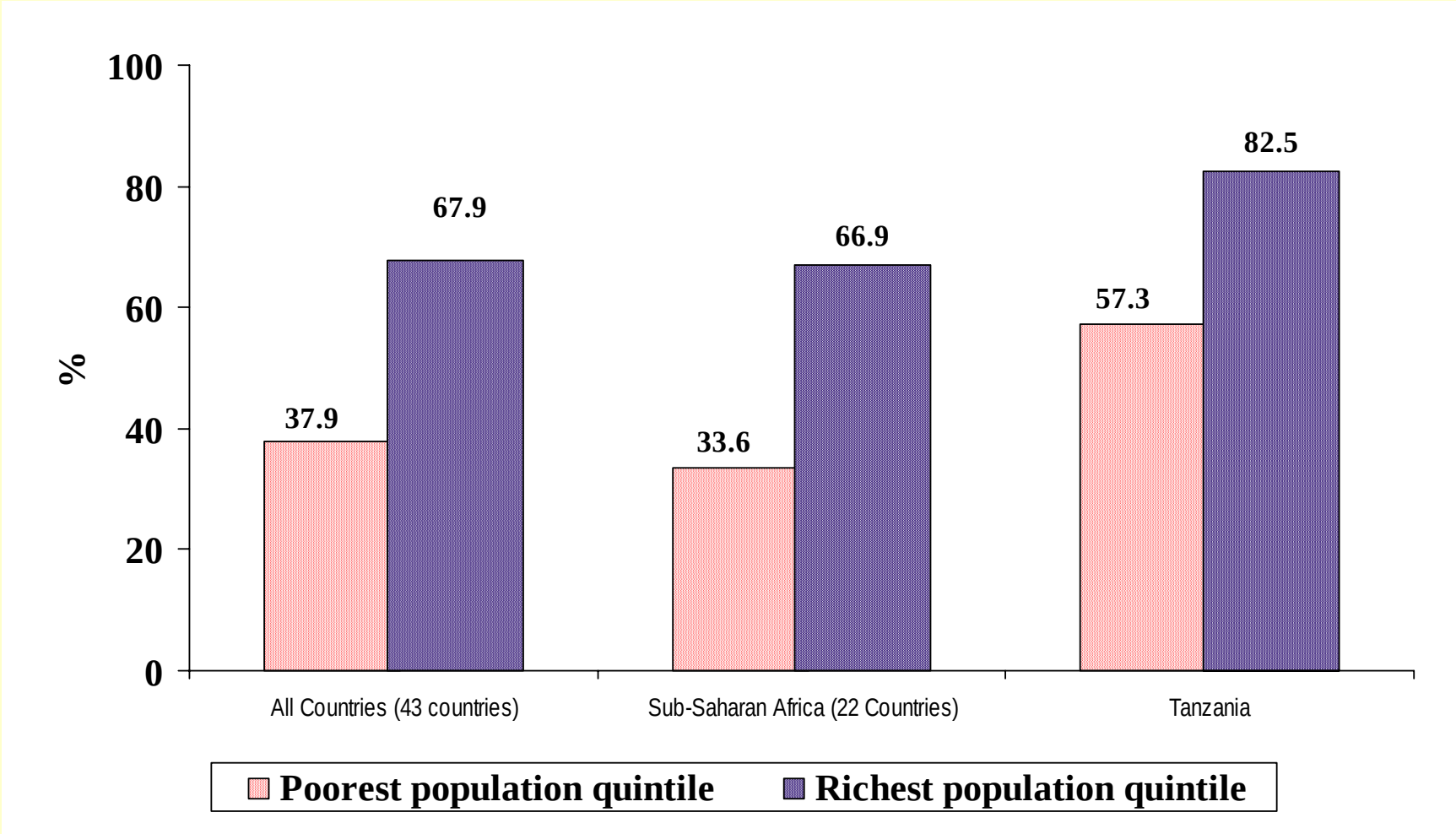
- **Yet, a 1990 analysis of changes in life expectancy in 94 developing countries ascribed *half the improvement* to the provision of preventive and curative health services**

What We Observe

- **About Health Conditions**
  - Communicable diseases burden poor communities
- **About Poor Households**
  - Households place a high value on health and recognize its relationship to poverty
  - Households underutilize existing services; esp. preventive
  - People often opt for private sector for some services, public sector for others
- **About Health Services**
  - Most government health services are far from poor communities
  - Nearby government health services do not function at a high level
  - Government health services are not responsive to health needs/demands of the poor
- **About Public Policy**
  - Rhetoric doesn't match reality (spending)

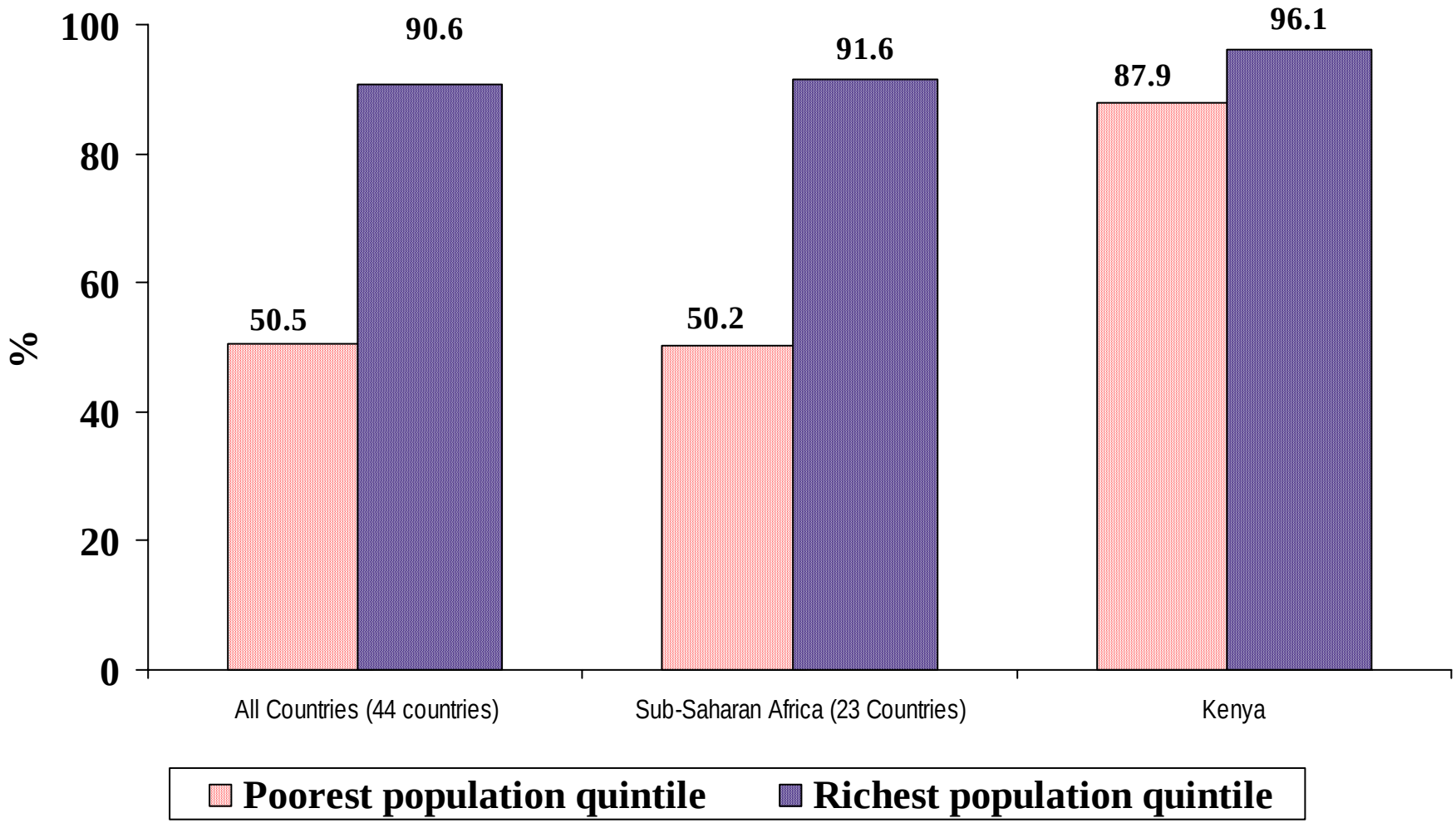
Poor/Rich Differences

Immunization Rates

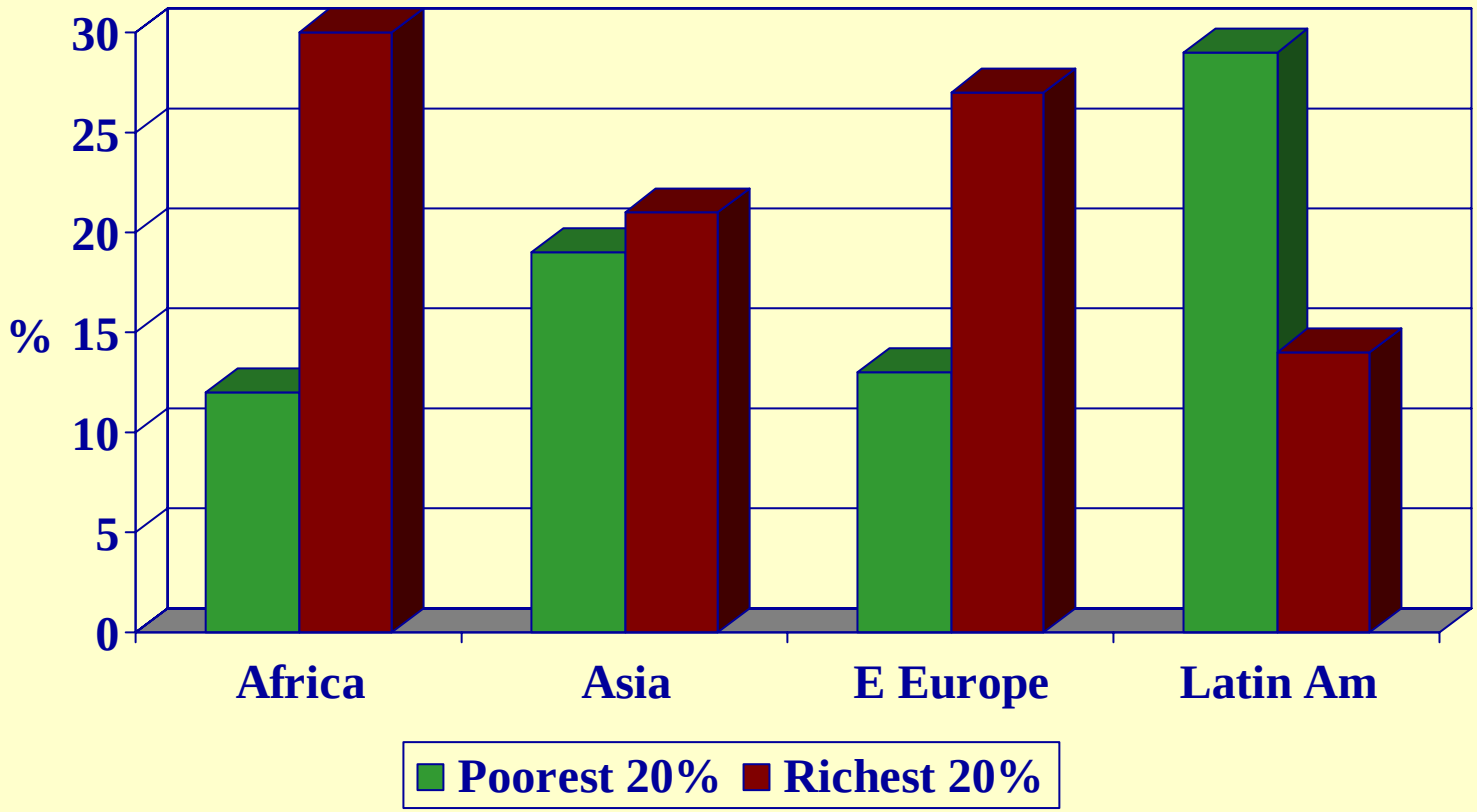


Poor/Rich Differences

Antenatal Care



Government Subsidy for Health



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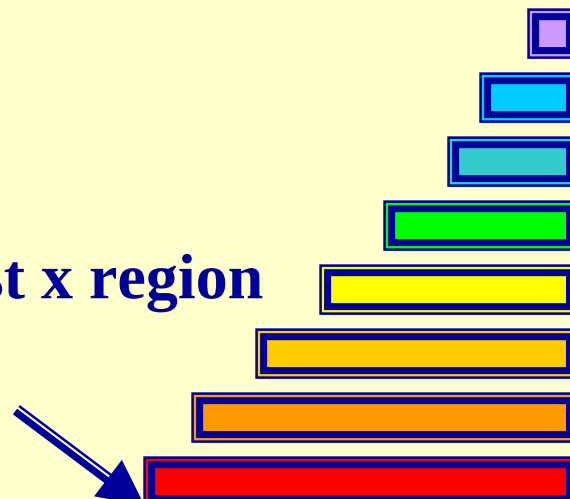
Eight Steps to Effective Coverage for the Poor

Physical Accessibility

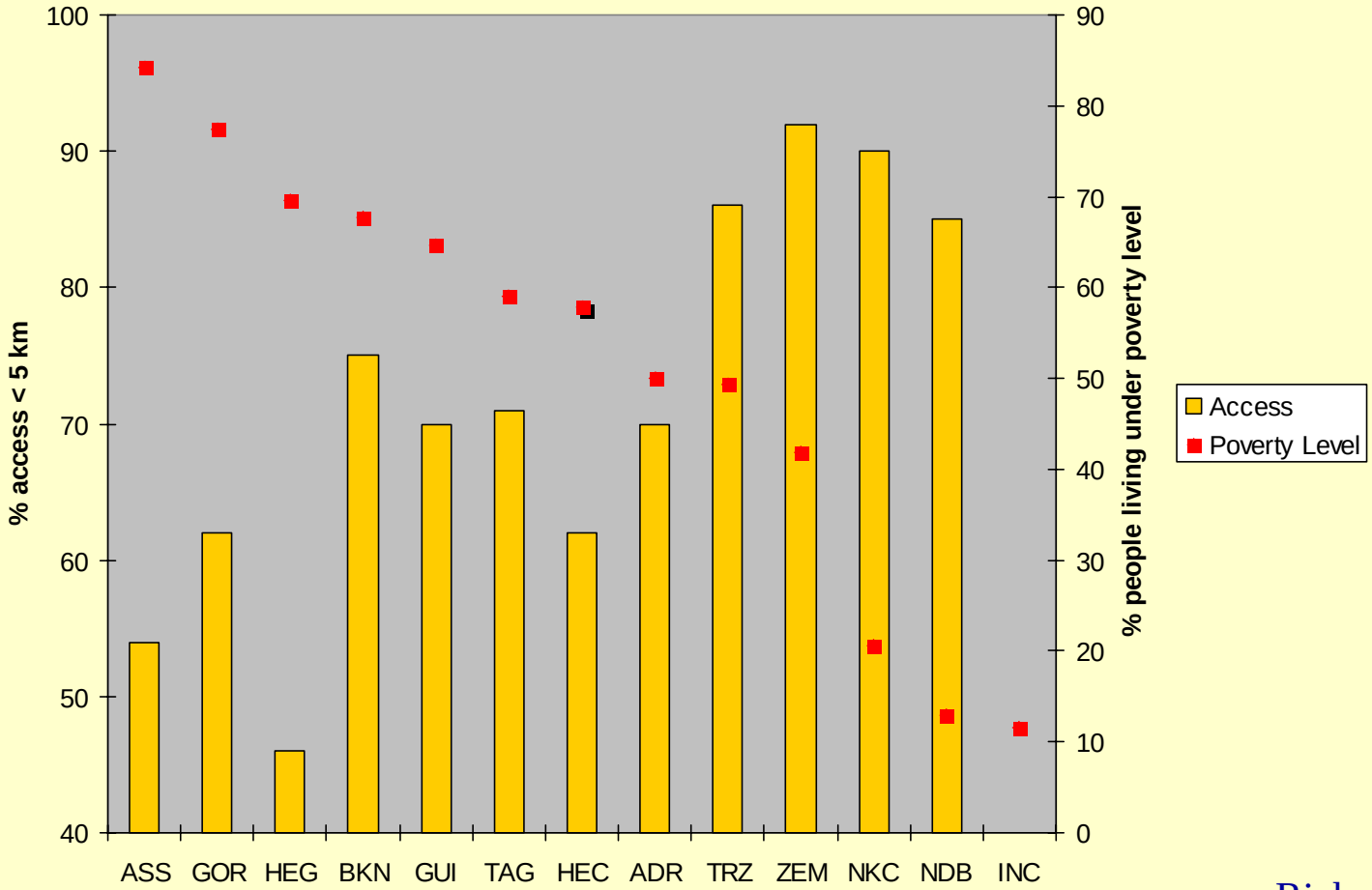
Diagnostics

- **Typical problem**
  - Low geographical access to clinic services, to community-based activities
- **Typical reasons**
  - Few facilities in remote areas
  - Lack of transport or costly, time-consuming transportation
  - Seasonal factors
- **Common indicator**
  - Population per facility, per hospital bed
  - Population within 5-10 km of health post x region
  - Travel time to health post x region



Physical Accessibility (Mauritania, 1999)

Access to Essential Health Services

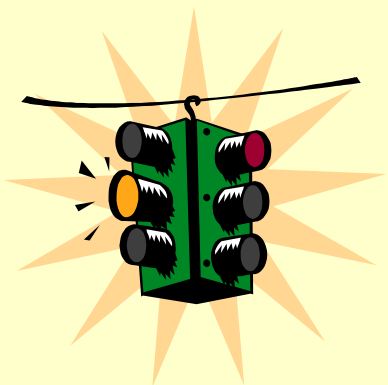


Poorer

Richer

Pro-Poor Actions

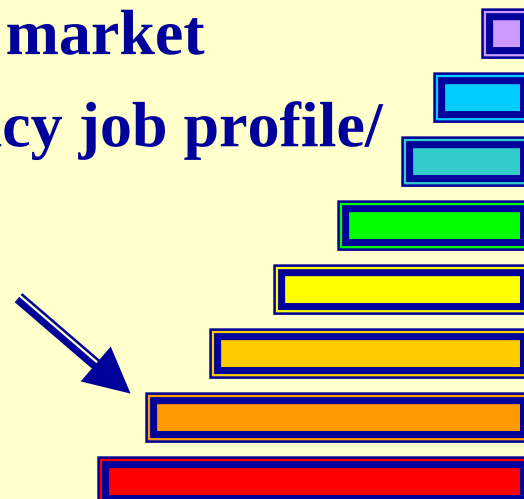
- Target priority investments towards poorer, less served areas
- Increase outreach activities for core interventions
- Alliances with NGOs to reach remote areas (East Africa, Guatemala, Cambodia, Thailand)
- Contracting with the commercial private sector (? Experiences?)



Availability of Essential Inputs (Human Resources)

Diagnostics

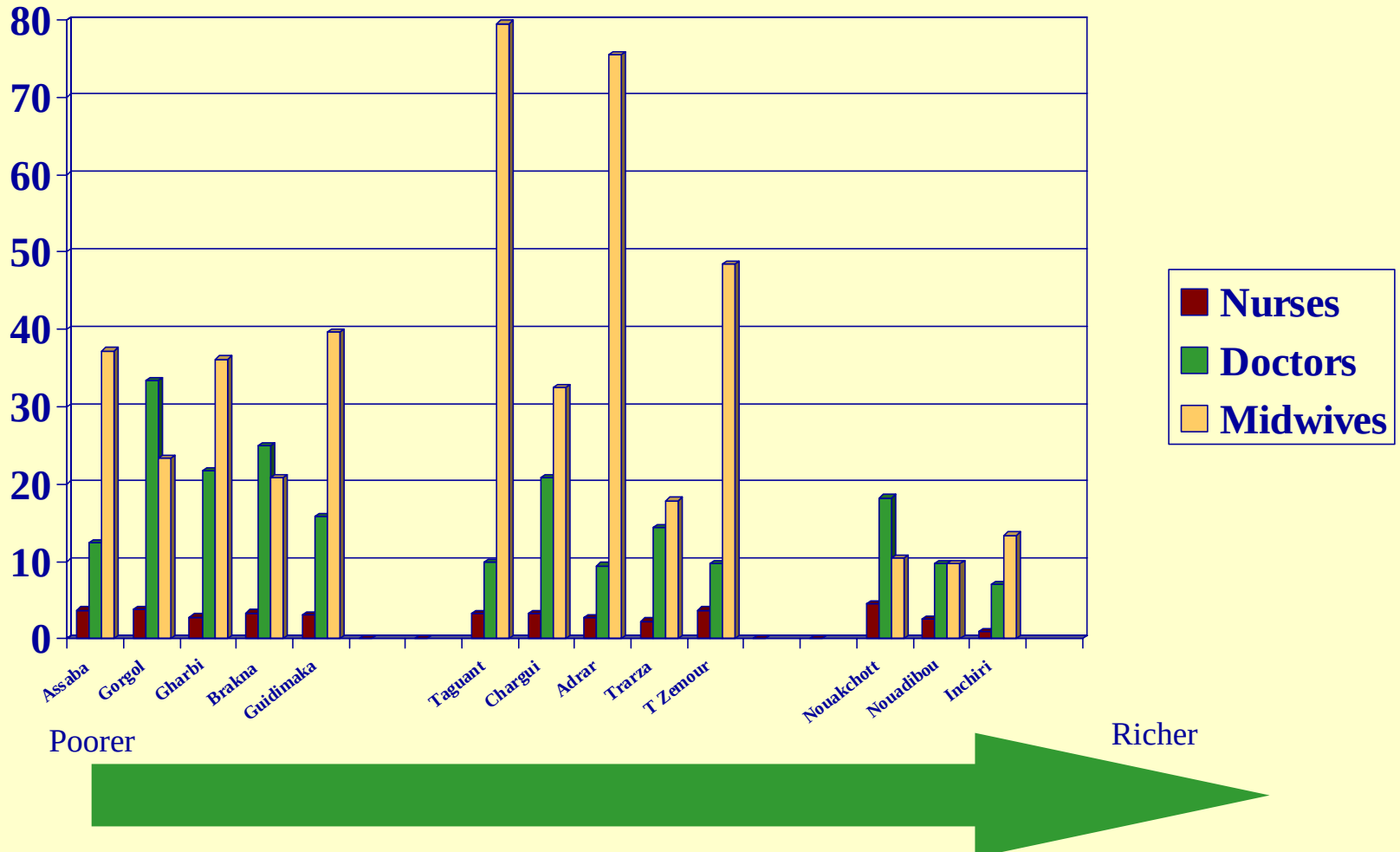
- **Typical problems**
  - Lack of trained staff (esp. physicians surgeons midwives) in remote, undesirable areas
  - Low motivation of staff to serve poorer groups
- **Typical reasons**
  - Poor deployment policies; no extra compensation for hardship posts
  - Wage gap with private internal and global market
  - Inappropriate scopes of practice, inadequacy job profile/ training
- **Common indicator**
  - Health workers:population x region
  - Health workers: norm x region



Availability of Essential Inputs (Human Resources)

Ratio Population to Health Personnel

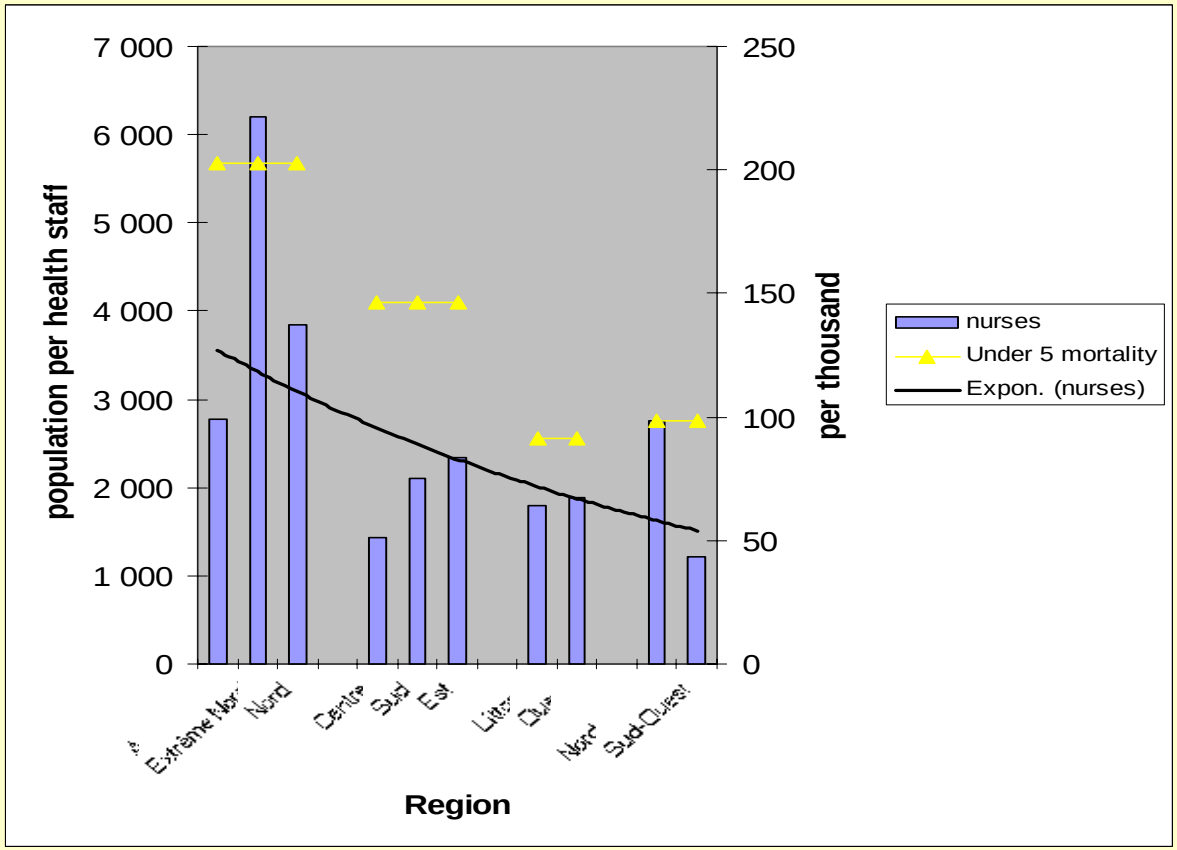
Mauritania 1999



Availability of Essential Inputs (Human Resources)

Availability of Nurses and IMR

Cameroon 1999



Availability of Essential Inputs (Human Resources)

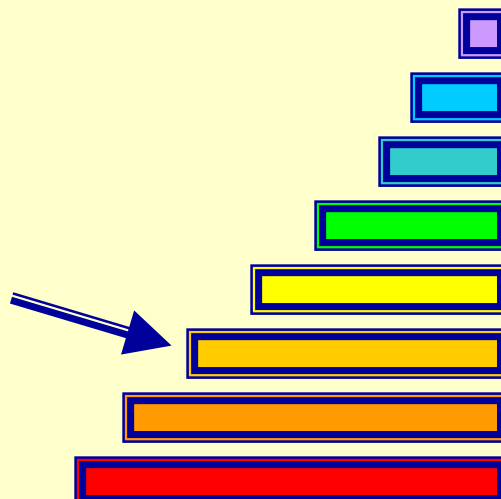
Pro-Poor Actions

- **Improved personnel policies, favoring hard-to-reach areas**
  - **Hardship pay**
  - **Performance based payments -contracting in-**
  - **Improved supervision**
  - **Rationalized job descriptions, health team composition**
  - **Contracting- out**
  - **Public private mix**

Availability of Essential Inputs (Consumables and Material)

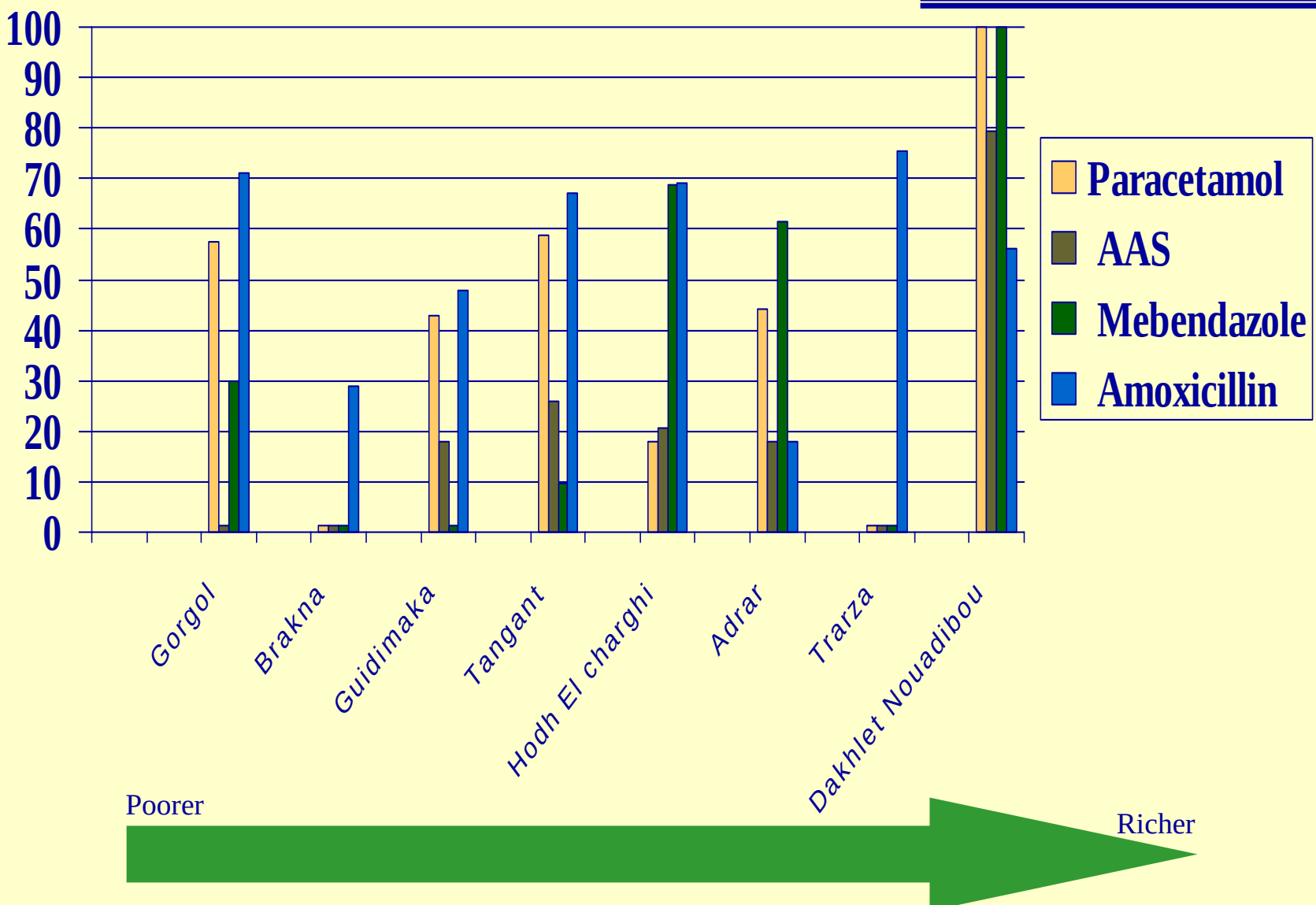
Diagnostics

- **Typical problems**
  - **Shortages of essential drugs**
  - **Low quality/fake drugs**
- **Typical reasons**
  - **Market failure**
  - **Poor management of drug supply**
  - **Supply driven financing of drugs**
  - **Common indicator**
  - **Prevalence of stock-outs x region**
  - **Source of medicines purchasing x SES**



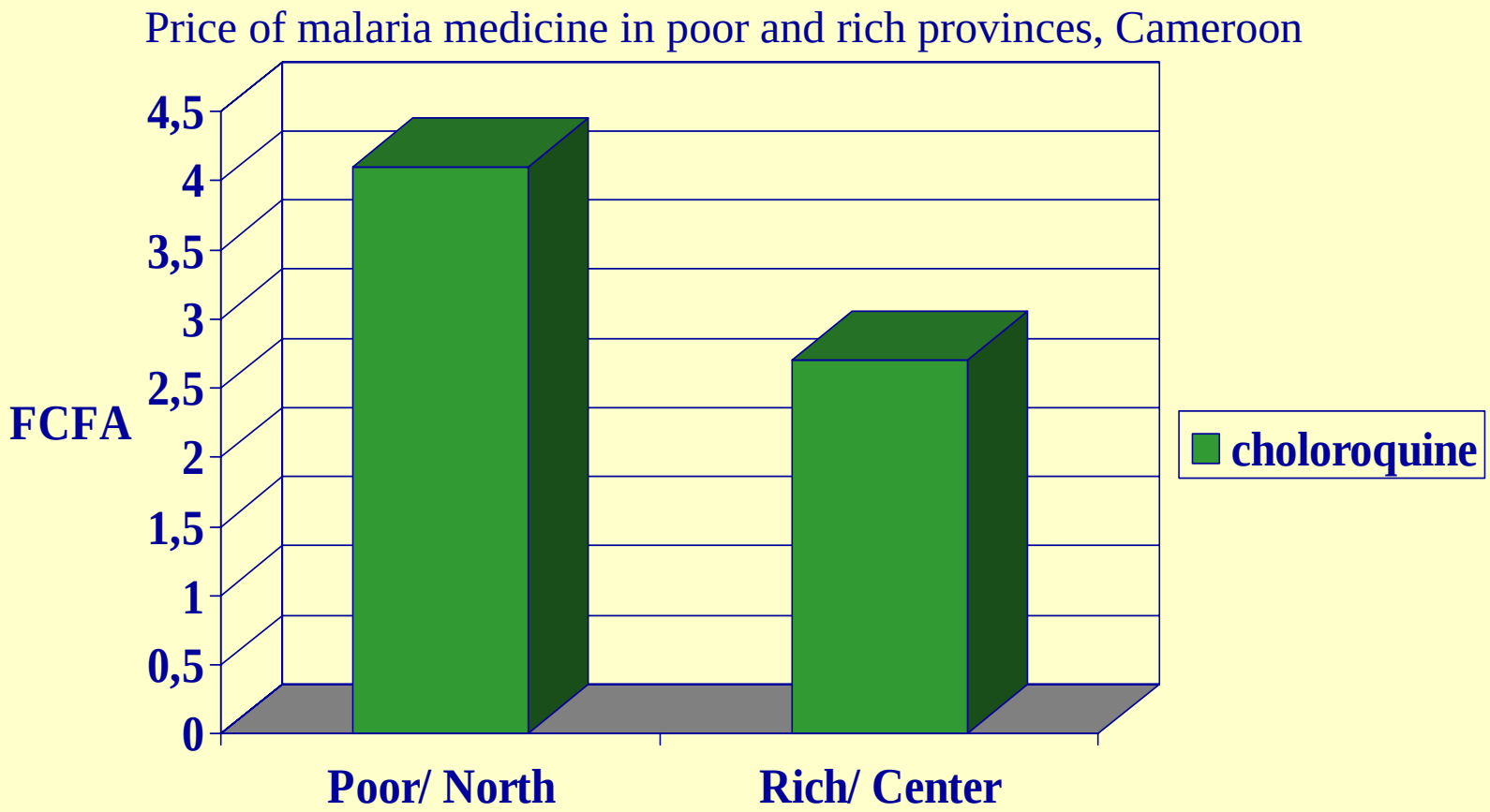
Availability of Essential Inputs (Consumables and Material)

Essential Drugs, Mauritania, 1999



Availability of Essential Inputs (Consumables and Material)

Affordability of Drugs



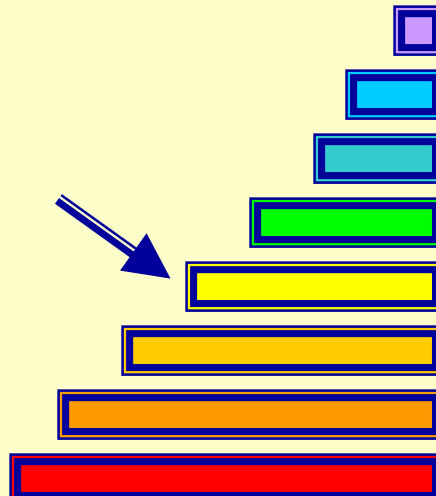
Availability of Essential Inputs (Consumables and Material)

Pro-Poor Actions

- **Improve drug management**
  - **Rigorous forecasting**
  - **Transparent procurement, reliable internationally certified providers**
  - **Out-sourced procurement, storage and distribution systems**
  - **Transparent management, co-management**
  - **Improved use: therapeutic guidelines**
  - **Mix of supply and Demand driven financing (eg Prepayment, Drug Revolving Funds, equity funds)**
  - **Pricing policies: control/capping, tier pricing**

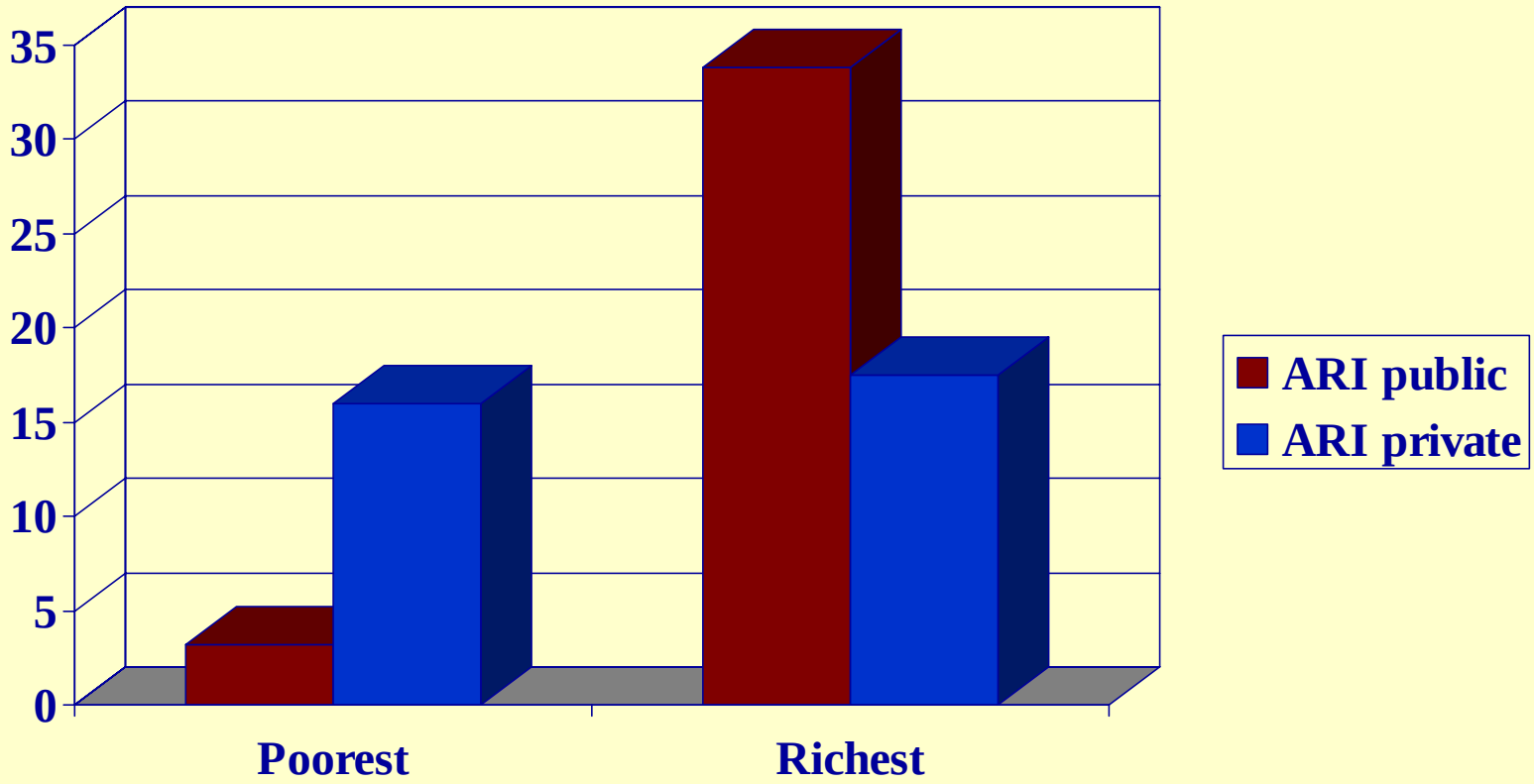
Diagnostics

- **Typical problems**
  - Long queues
  - Under-utilization of facilities
  - Lack of respectful care, privacy
- **Typical reasons**
  - Social distance between provider and community
  - Lack of systematic participation by community, civil society
  - Poor service management
- **Common indicator**
  - Waiting time x region
  - Use of private services by poor
  - Time spent by providers with patients
  - Qualitative studies (focus groups)



Perceived Organizational Quality

Utilization of private services for ARI in children less than 3: Cameroon

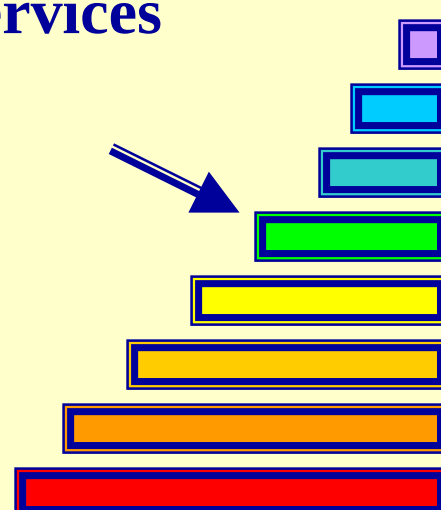


Pro-Poor Actions

- Introduce citizen oversight arrangements
- Train staff
- Include consumer satisfaction measures in performance evaluation
- Encourage development, formalization of advocacy groups
- Disseminate information about “patients’ rights”

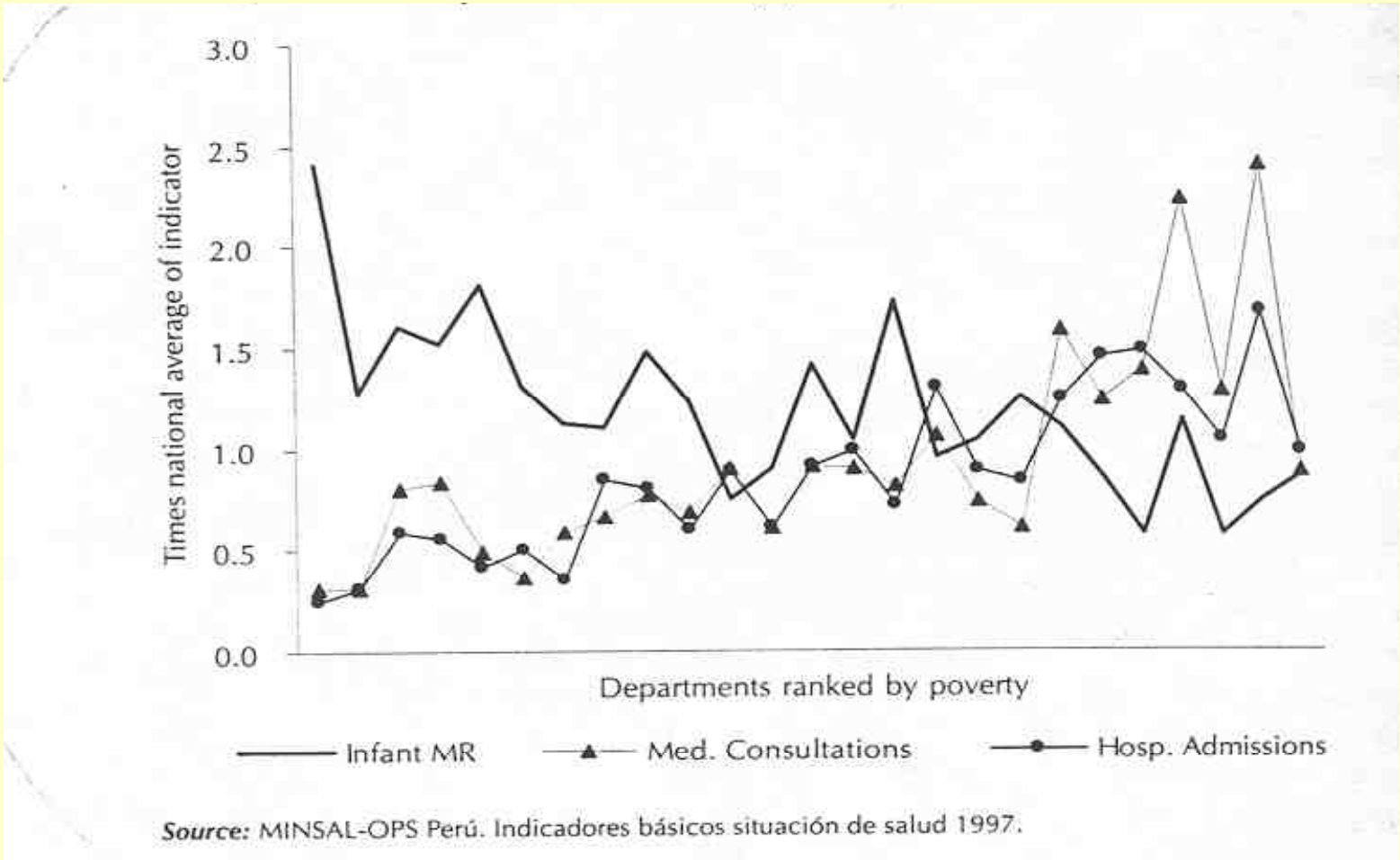
Diagnostics

- **Typical problems**
  - Little correlation between burden of disease and services provided
  - Disproportionate supply of curative services
- **Typical reasons**
  - Lack of norms or norms not applied
  - Financial Incentives favor less essential services
  - “Need” is not the same as demand
- **Common indicator**
  - Mapping of production x health conditions and/or income



Service Production and Poverty

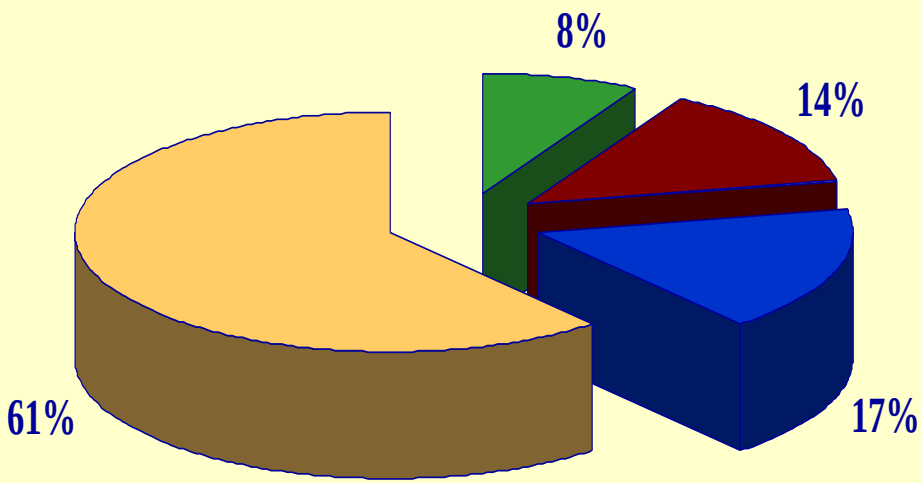
Differential pattern of health (infant mortality rate and access/use of services (medical consultations and hospital admissions) in departments ranked by poverty, Peru 1997



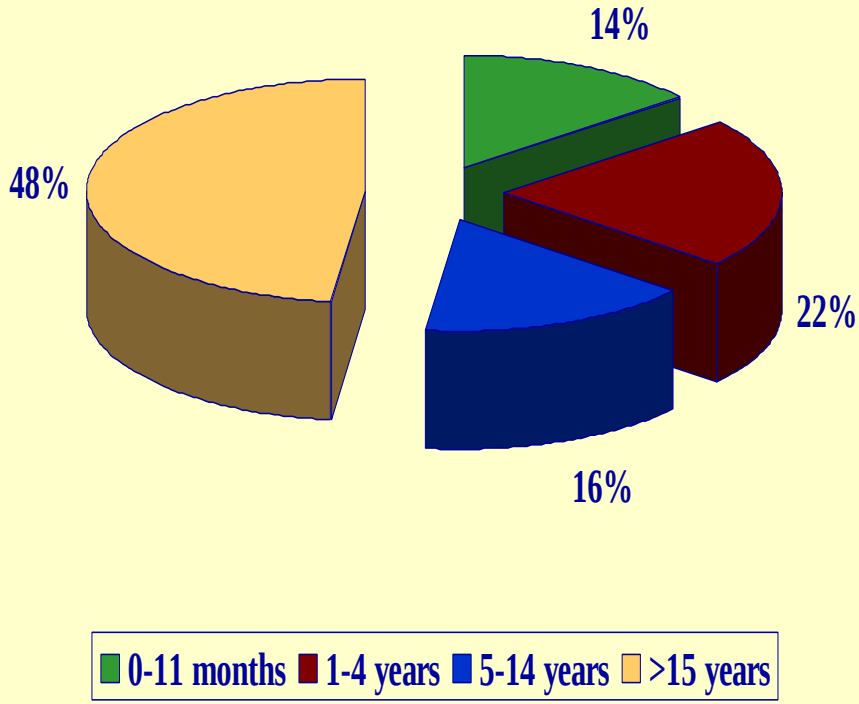
Source: MINSAL-OPS Perú. Indicadores básicos situación de salud 1997.

Consultations Age Mix, 1998

Mauritania

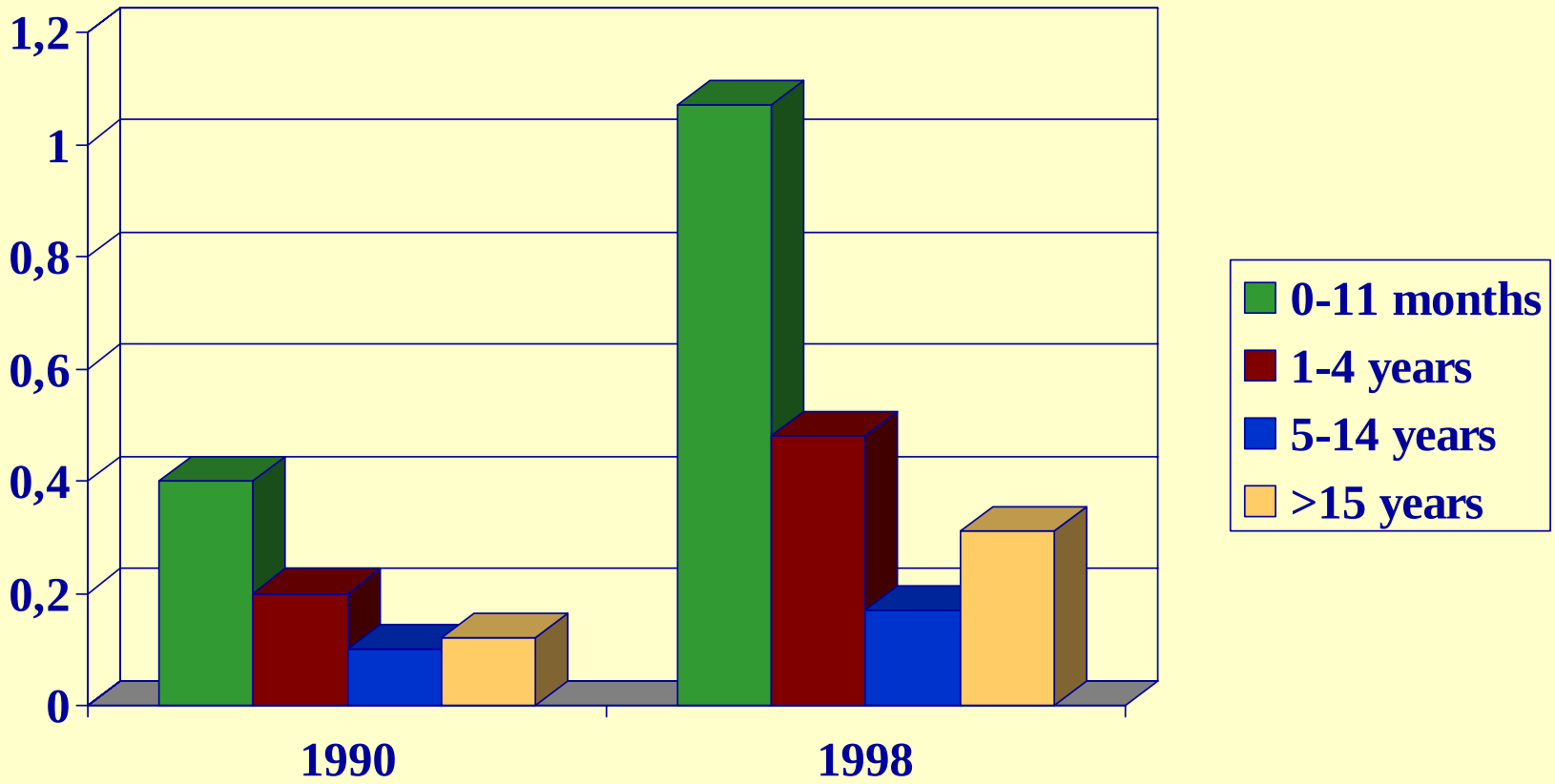


Benin



Utilization Rates by Age Category

Benin 1990-1998



Pro-Poor Actions

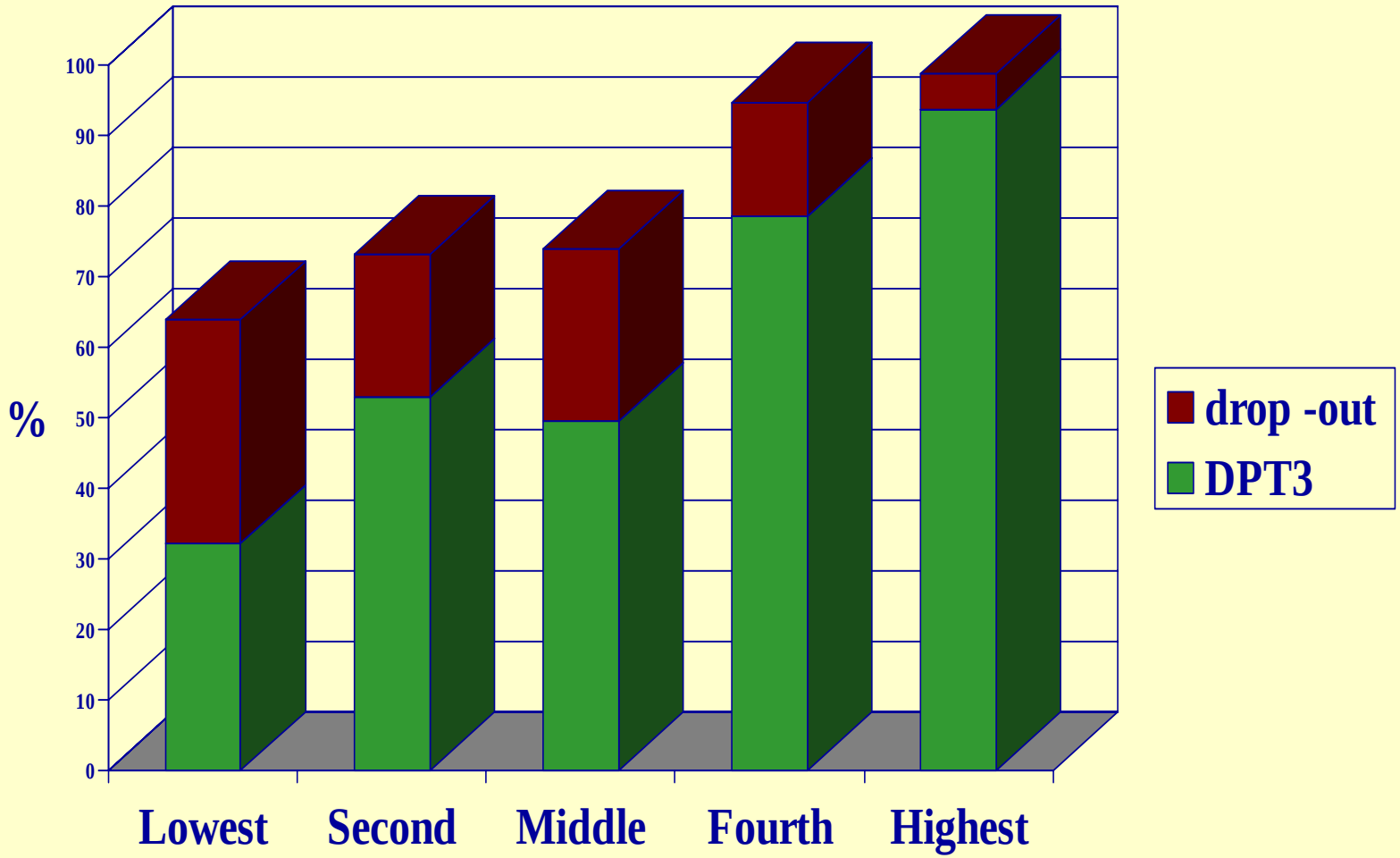
- Establish core package, and consider financing on a capitated basis
- Focus government resources on core services only; encourage private sector to provide other services demanded
- Contract with NGOs, other private providers for delivery of core services

Diagnostics

- **Typical problem**
  - Weak links with community structures
- **Typical reasons**
  - Lack of norms
  - Inadequate training
  - Poor supervision
- **Common indicator**
  - Immunization and ANC patterns among the poor
  - Qualitative study (situation analysis)

Continuity of Immunization

Drop-out Rates Mozambique 1997

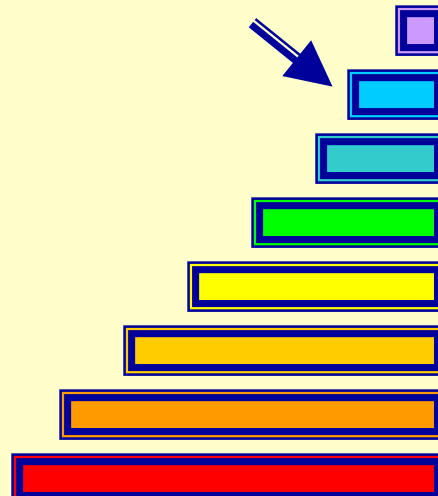


Pro-Poor Actions

- Establish formal avenues for community and civil society participation
- Mapping, canvassing, active channeling (Philippines, Zimbabwe)
- Improve pre- and in-service training
- Improve supervision

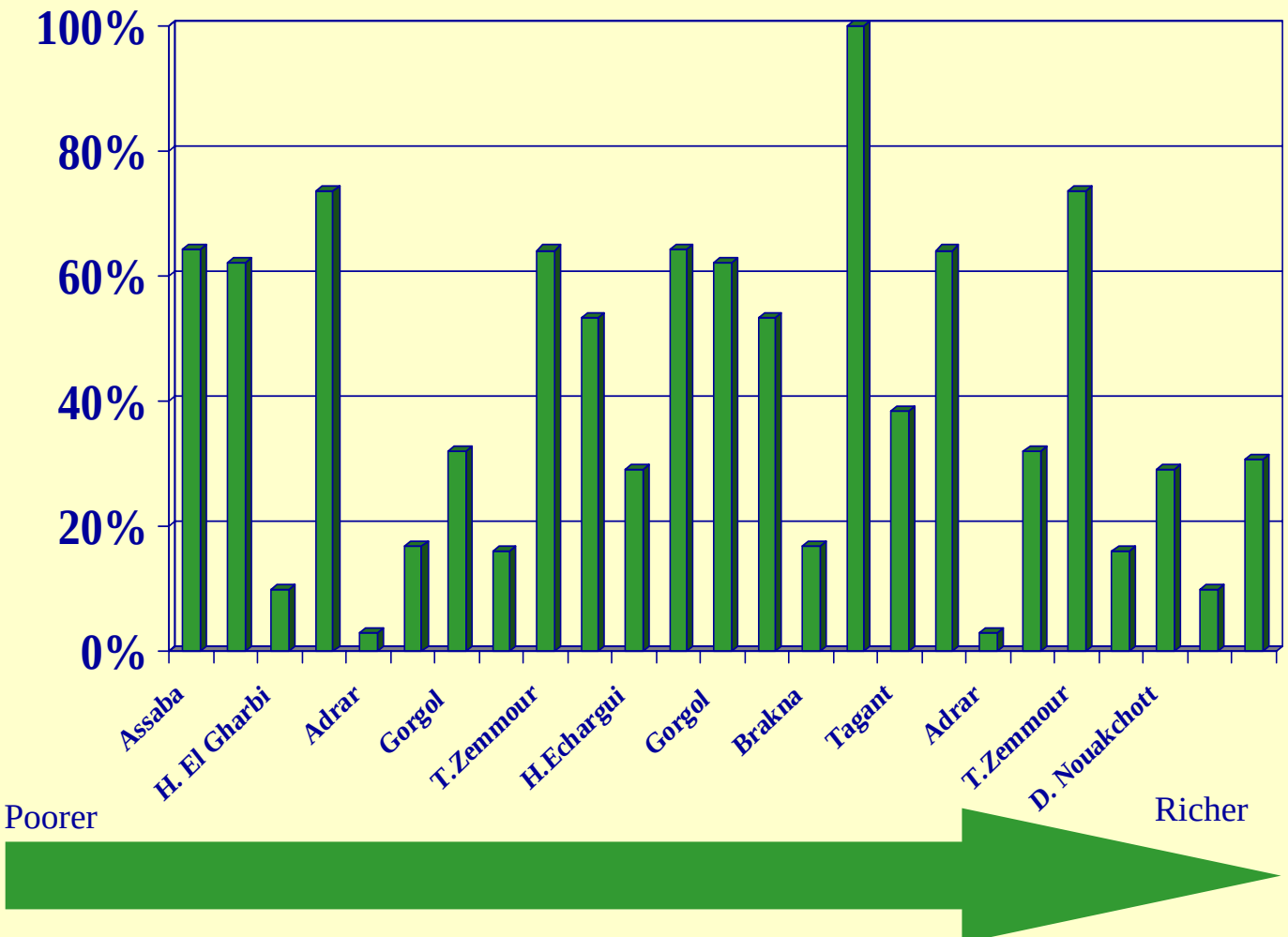
Diagnostics

- **Typical problem**
  - Inefficacious services delivered; efficacious services not provided
- **Typical reasons**
  - Lack of “technology assessment” (broadly defined)
  - Lack of use of practice guidelines, standards
  - Poor training
  - Inadequate supervision
- **Common indicator**
  - Health facility surveys, exit surveys
  - Qualitative study (situation analysis)



Quality Standards (Care Package)

Mauritania 2000



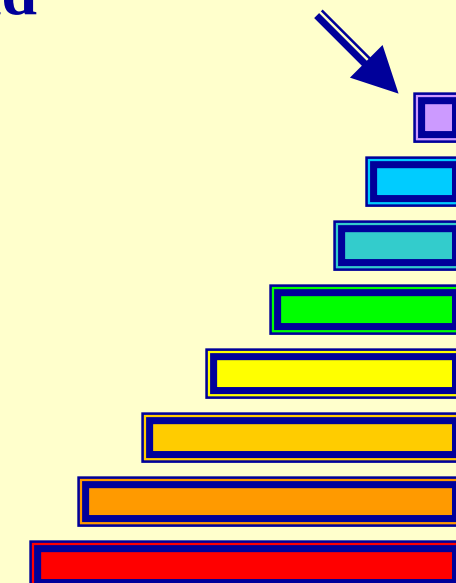
Pro-Poor Actions

- Improve drug management, with special focus on rational drug use
- Improve pre- and in-service training on the basis of diaagnostic and treatment algorithms
- Improve supervision
- Performance based payments
- Contract with NGOs, commercial private sector, based on results

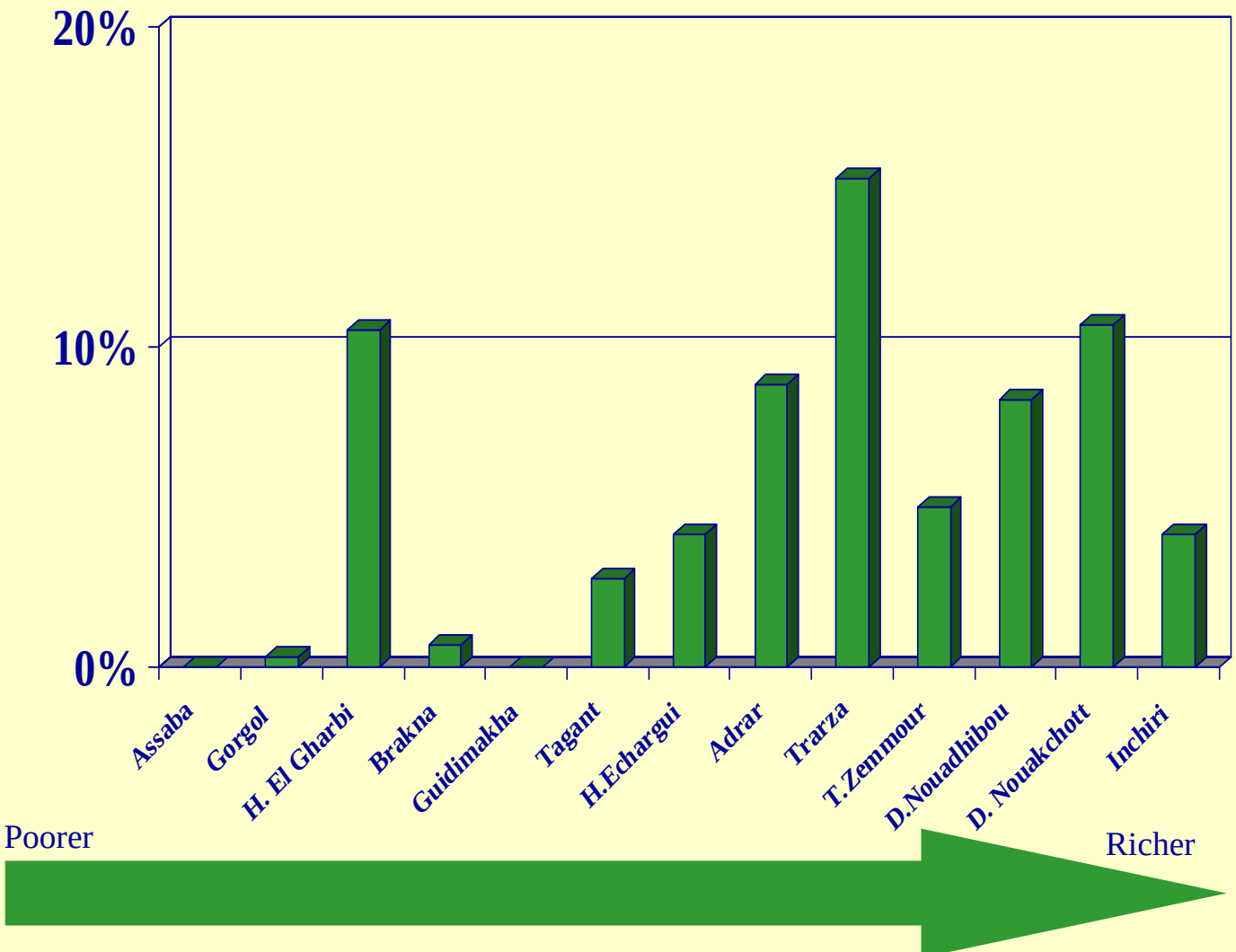
Social Accountability

Diagnostics

- **Typical problem**
  - Services are unresponsive to needs, characteristics, demand of the poor
- **Typical reason**
  - Poor have no voice in service delivery
  - Poor are not participating in planning and management of health services
- **Common indicator**
  - Qualitative study (situation analysis)



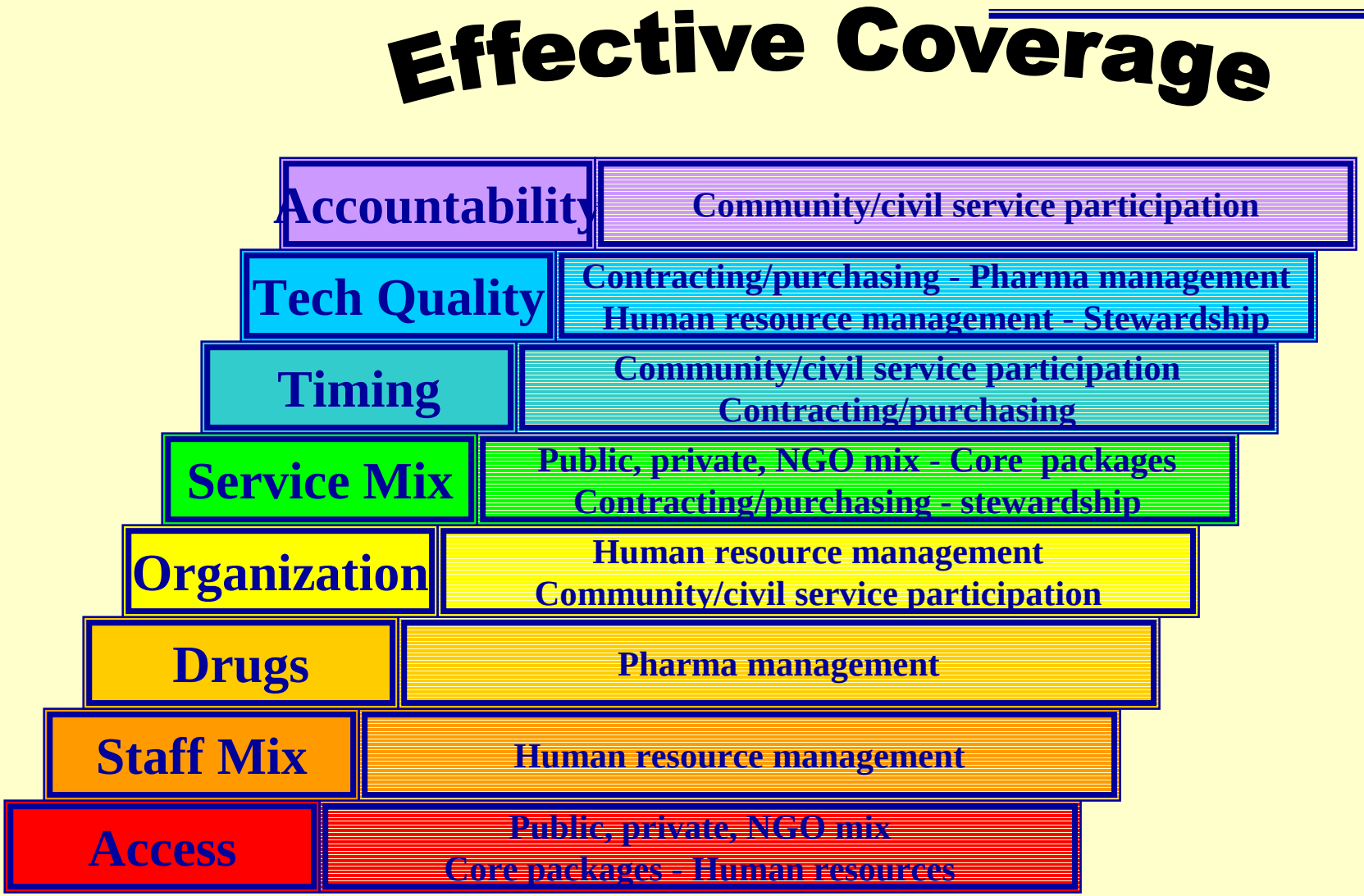
Participation Rate: Mauritania 2000



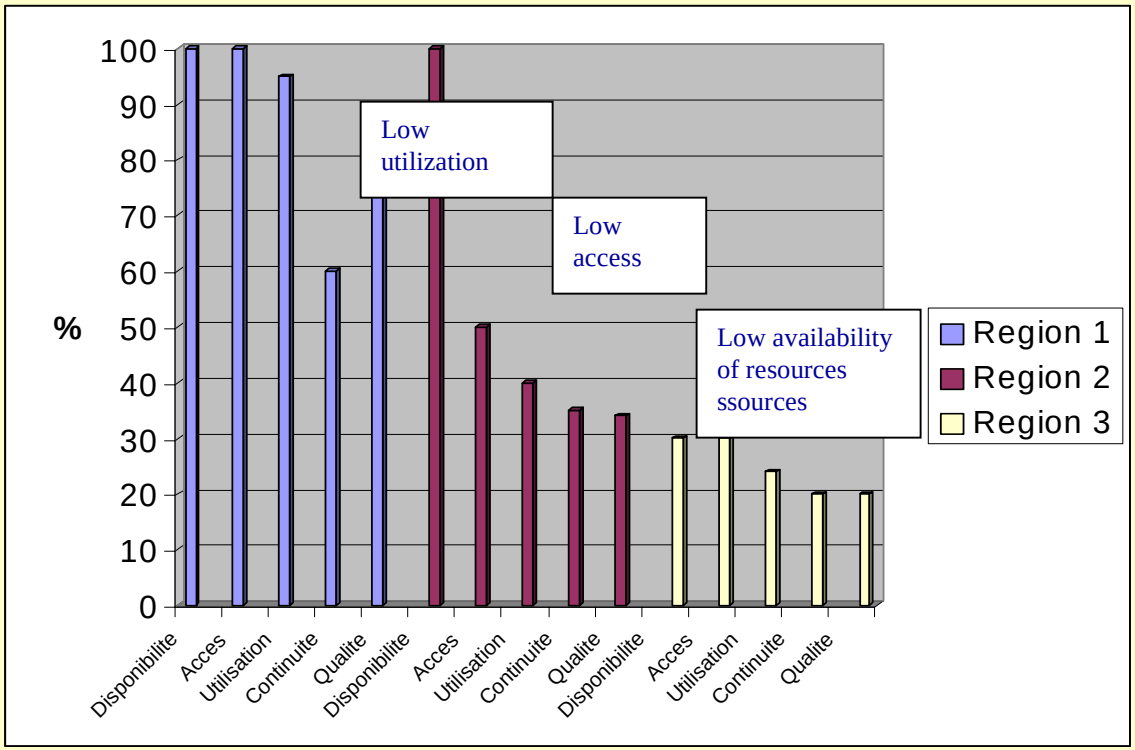
Pro-Poor Actions

- Establish and/or improve formal avenues for community and civil society participation (such as management committees, hospital or regional health boards,)
- Affirmative action actively promote participation of vulnerable groups in these institutions (women, minorities, poor communities, patients -PLWAs)

Summary of Eight Steps



Systemic Obstacles by Region, Cameroon, 1999



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- **Health financing and the poor**
  - **patterns of government spending**
  - **strategies for mobilizing resources**
- **Setting priorities**
- **Communicating analyses and recommendations**

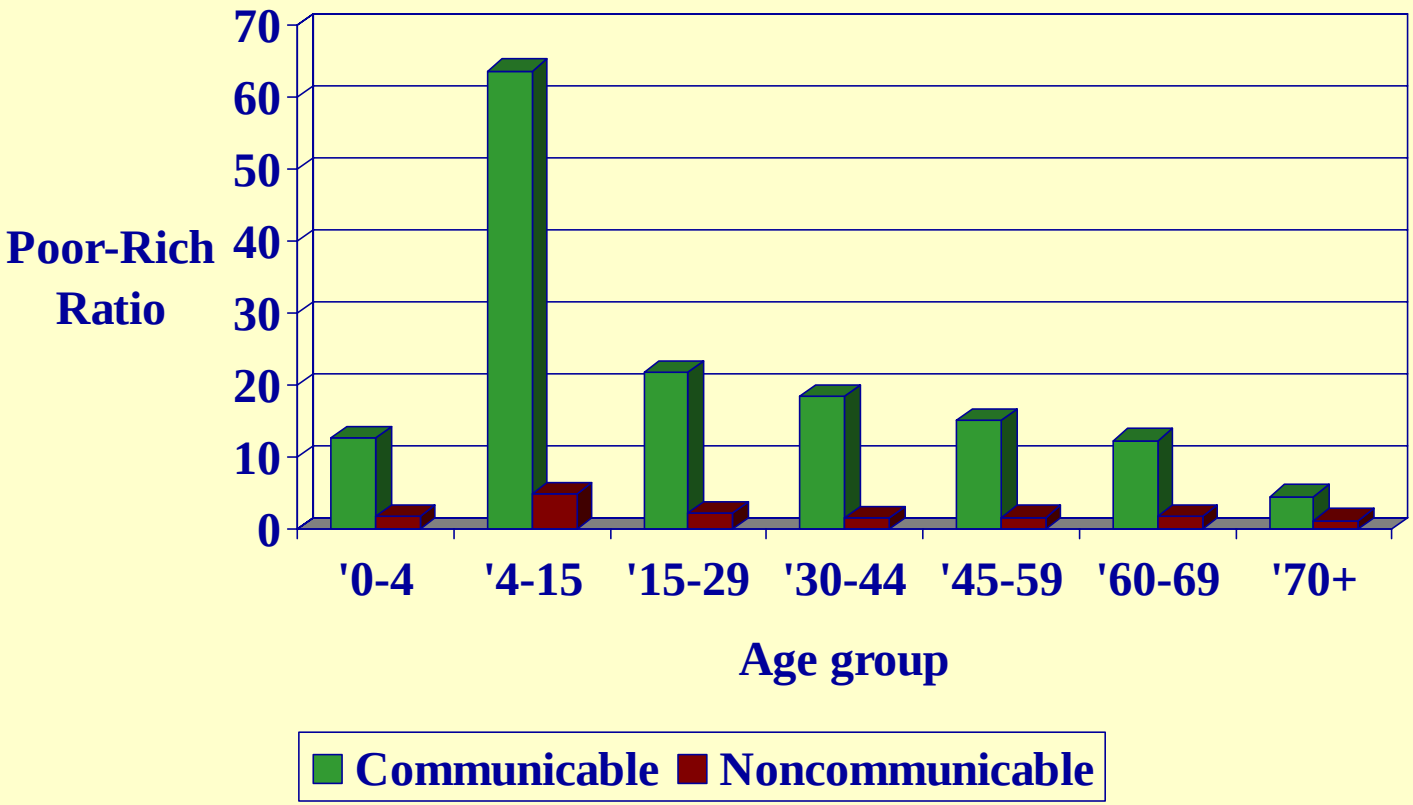
Core Questions for Overview of Health Financing

- **Patterns of government spending: On what, for whom? [allocative efficiency, technical and input efficiency, equity]**
- **Sources and mechanisms of financing: Who pays for health services, what kind, and delivered by whom (government, commercial, non-profit)**
  - **User fees: Who pays, how much and for what services?**
  - **Insurance: Who is covered, and what is in the benefit package?**

Allocative Efficiency

- **Key question:**
  - **Is the public spending focused on pure (or nearly pure) public goods?**
  - **Is the public spending focused on activities that are most likely to contribute to impact health status and therefore economic development and poverty reduction?**
  - **Is the public spending focused on activities that are most likely to benefit the poor?**
- **Analytic tool:**
  - **Public expenditures review**
    - **How much, and for what?**
  - **Sub-national budgets**
    - **How much, for what…and where**

Age and Diseases: Interventions and Age Groups



(Source: calculations by Guillot, published in Gwatkin and Guillot, 1998)

Allocative Efficiency

Diagnostics

- **Typical problems**
  - Low funding of public goods
  - Low funding of cost-effective clinic services and population-based interventions likely to contribute to health impact
  - Relatively high spending on low-impact services that benefit few
- **Typical reasons**
  - Poor government trying to provide all services, universal
  - insufficient evidence based advocacy and decisionmaking
  - Differential power of constituencies

Pro-Poor Actions

- **Adequate financing of public goods**
- **Financing of interventions targeting children under 5, reproductive health**
- **Financing of communicable disease control**

Technical Efficiency

Diagnostics

- **Typical problems**
  - Unreliable, insufficient funding of key inputs (drugs)
  - Low utilization of government services
- **Typical reasons**
  - Inappropriate mix of inputs: eg salaries crowding out other inputs, non salary recurrent “recycled” into staff incentives
  - Poor input management
  - Vicious cycle of poor quality-under-utilization
- **Analytic tools**
  - Public expenditure reviews
  - Analysis of utilization
  - Public-private comparisons

Pro-Poor Actions

- **Incentives structure for health staff**
- **Transparent management systems, accountable to population**
- **Standards for service delivery and purchaser payment**
- **Regulation (e.g overinvestment)**

Equity in Spending

Diagnostics

- **Typical problems**
  - Regressive distribution of government health spending
  - Relative to their health needs, funding for women's health care is lower than funding for men's
- **Typical reasons**
  - Inequitable distribution of resources
  - Urban elite capture government resources
  - Lack of information about health needs, gaps
- **Common indicators**
  - Public spending and/or utilization of specific services x income group (benefit-incidence)

Steps in Benefit-Incidence Analysis

- **STEP 1. Estimate the unit cost or unit subsidy (in current expenditures) of providing a service [use expenditure studies or public budgets and service statistics]**
- **STEP 2. Impute the unit subsidy to households or individuals who are identified as users of the service [use household survey data on utilization, with income measures]**
- **STEP 3. Aggregate individuals (or households) into subgroups of the population to compare distribution of the subsidy among groups (income, gender, etc.).**

Some Available Information

Percentage of Financial Subsidy from Government Health Services Accruing to Poorest and Richest 20%

Country	Year	Primary care		Total Health Care	
		Poorest 20%	Richest 20%	Poorest 20%	Richest 20%
Cote d'Ivoire	1995	14	22	11	30
Ghana	1992	10	31	12	33
Guinea	1994	10	36	4	48
Kenya (Rural)	1993	22	14	14	24
Madagascar	1993	10	29	12	30
South Africa	1994	18	10	16	17
Tanzania	1993	18	21	17	29
Indonesia	1990	18	16	12	29
Vietnam	1993	20	10	12	29
Bulgaria	1995	16	21	13	25
Romania	n.a.	16	22	12	29

(Source: data assembled from variety of sources by Gwatkin 2000)

Pro-Poor Actions

- **Resources allocation according to population, needs (standardized mortality ratios) and … poverty levels**

- **Specific “catch-up” programs**
- **Transfers and demand side measures: social/equity funds**

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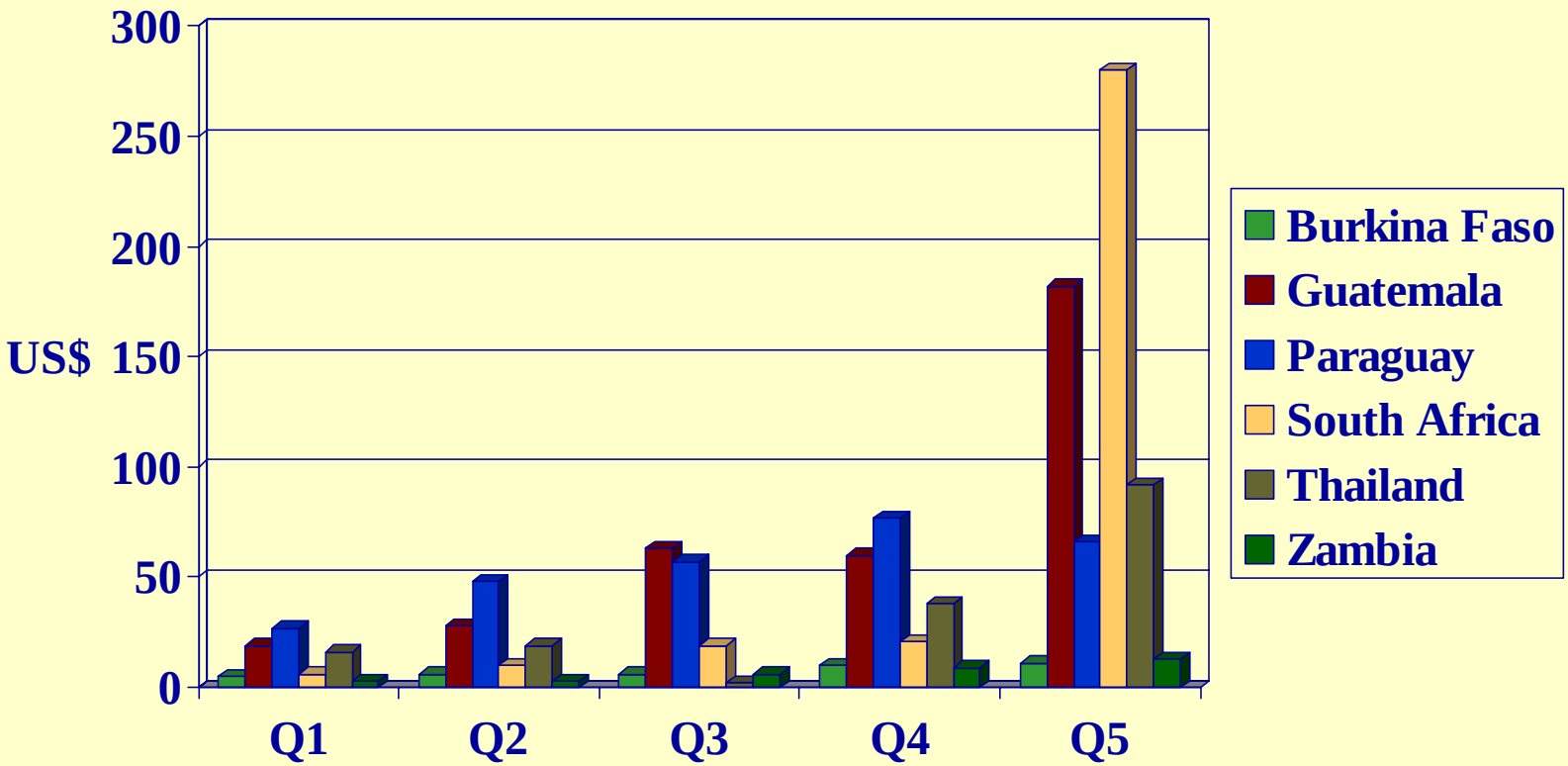
  - **Insurance: Who is covered, and what is in the benefit package?**

Diagnostics

- **Typical problems**
  - Formal user fees are unaffordable
  - Side payments are unaffordable
  - Insurance serves only urban elite, formal sector workers
  - Insurance coverage is inadequate even for beneficiaries
  - Exemptions are used for influential individuals
- **Typical reasons**
  - Exemption mechanisms are too cumbersome, Health workers compensate for low pay with side payments
  - Failures in insurance market, lack of grouping mechanisms
- **Typical indicators**
  - HH spending on health services x income, residence (absolute and relative to total income)
  - Insurance coverage x income, residence
  - Average co-payments for various basic services

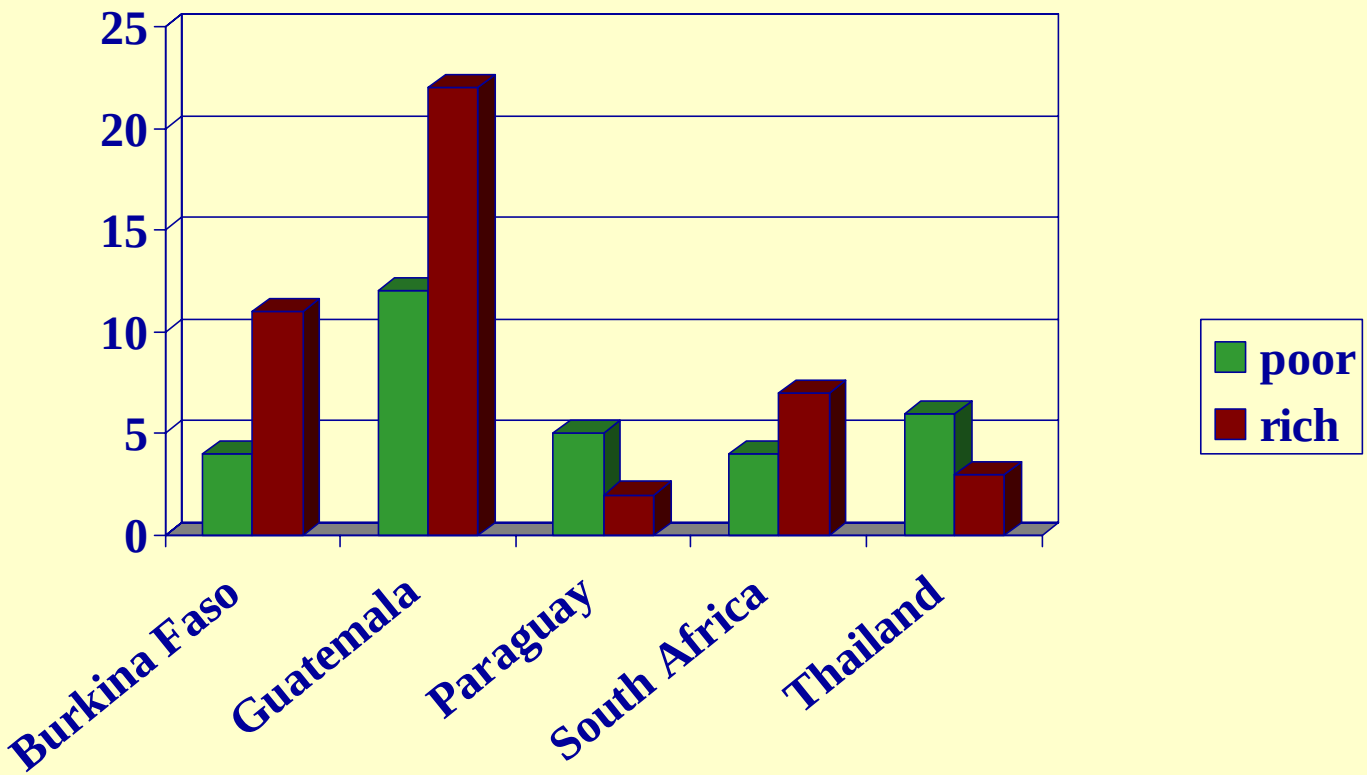
Household Spending

Health Expenditures by Income Quintile: Selected Countries



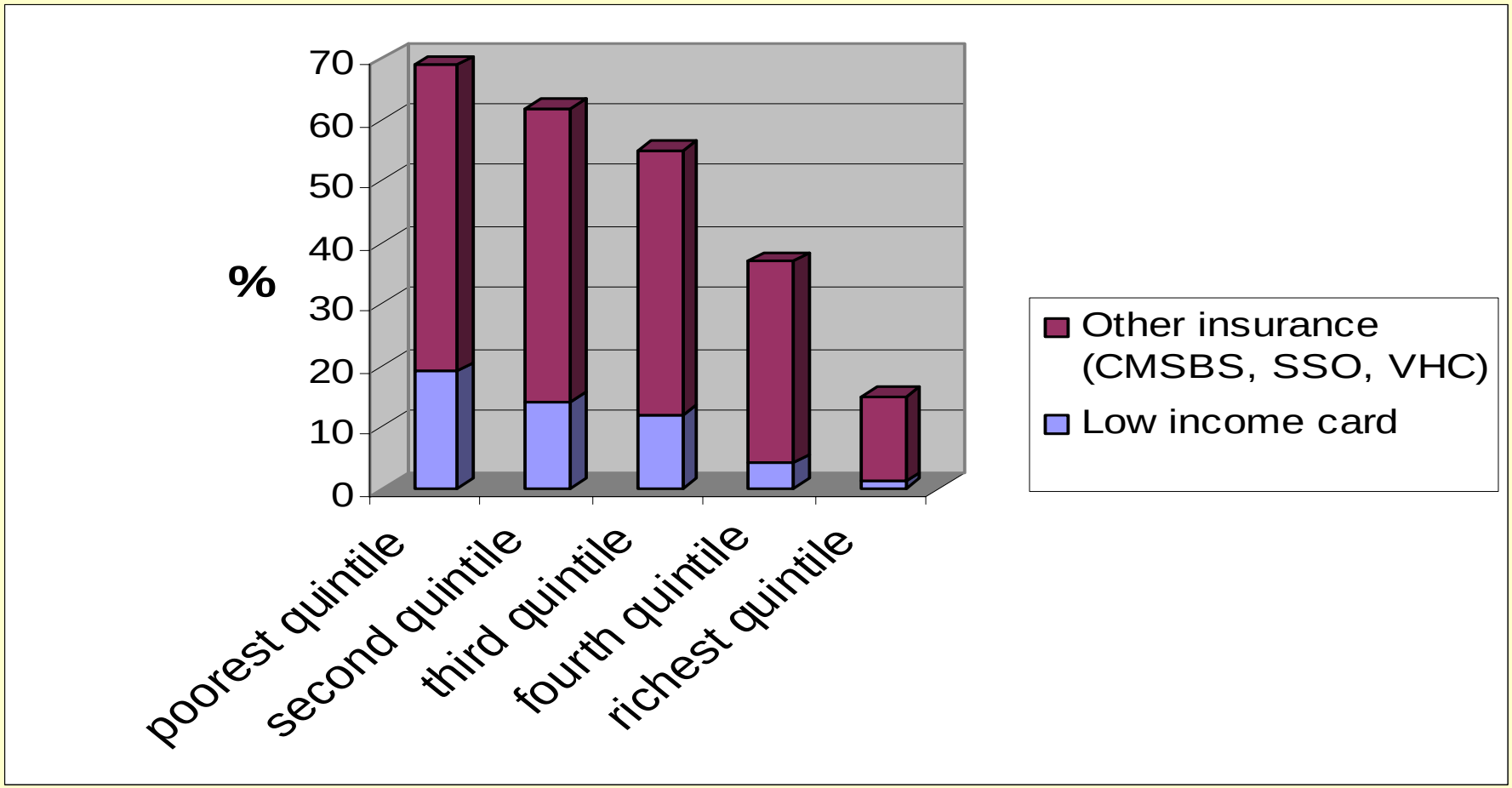
Household Spending

Health spending as a total of household spending, 1995



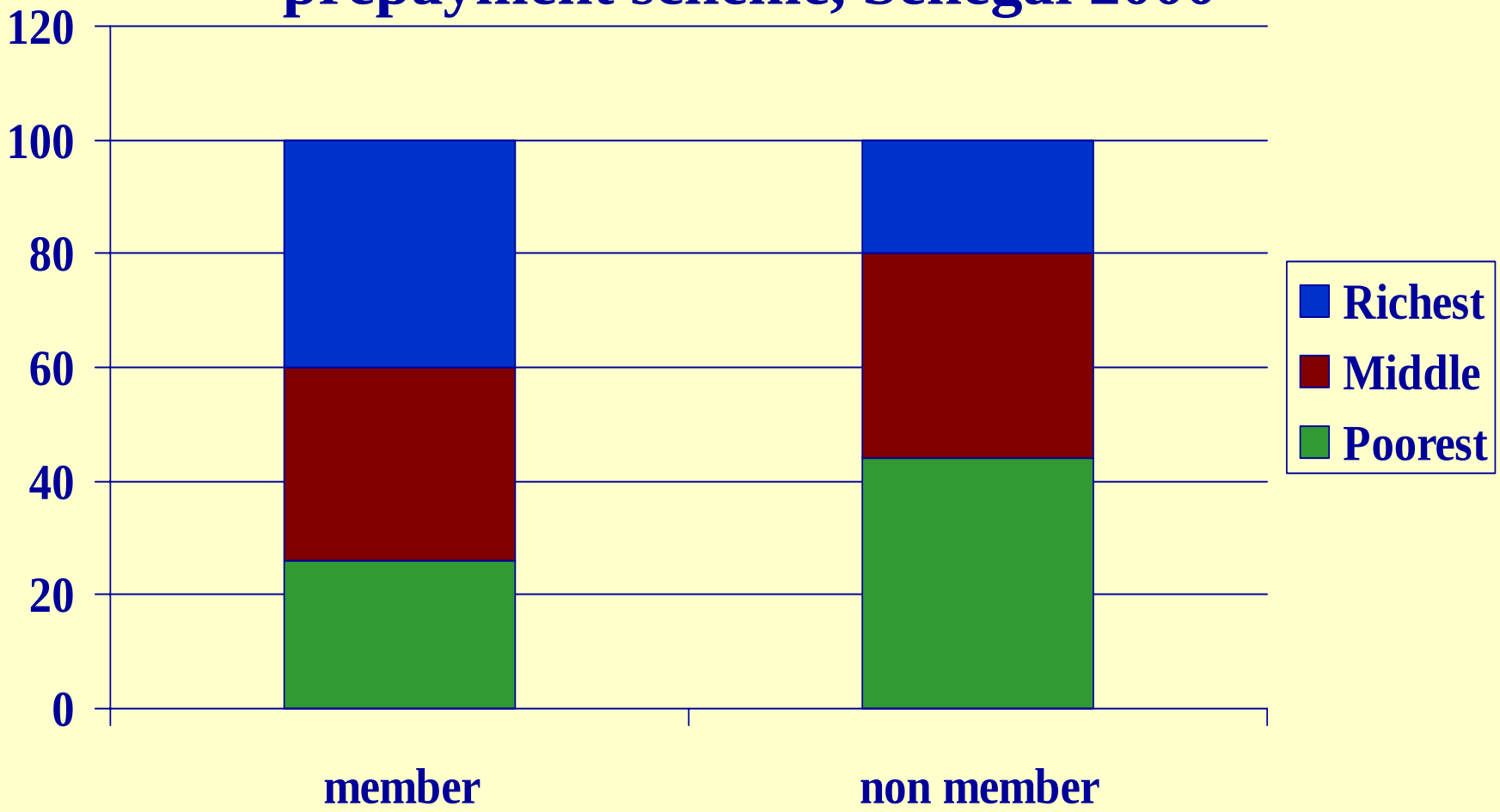
Insurance

Population covered by publicly funded health insurance by SES: Thailand 2000



Insurance

Socio-Economic Status of enrollees into prepayment scheme, Senegal 2000



Key Questions (1)

- What do the poor pay out-of-pocket?
  - What is the exemption mechanism
- Who is covered by insurance?
  - Employer-based?
  - Dependents?
- What is covered by insurance?
  - Catastrophic care?

Key Questions (2)

- How much risk-sharing exists?
  - What are the co-payments?
- How much does insurance coverage cost?
  - Property, income, payroll taxes?
  - Private premiums (employer, household)?
- What is the cost of services not covered by insurance?

Pro-Poor Actions

- Pricing policy that reduces and/or eliminate user fees for basic services
- Cross-subsidization
- Strengthen exemption mechanisms
- Expand social insurance to cover informal sector workers
- Develop community financing arrangements
- Develop equity funds to pay for the poor (copayments and/or prepayments)

This Session's Messages

- **How well the health system meets the needs of the poor can be assessed systematically, looking at a full range of determinants of effective coverage.**
- **Specific dimensions of health system financing are essential in understanding how to improve the health of the poor.**